FINANCIAL SERVICES COMMISSION

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

TARGET MARKET CONDUCT FINAL EXAMINATION REPORT

OF

UNITED AUTOMOBILE INSURANCE COMPANY

AS OF

May 25, 2007

NAIC COMPANY CODE: 35319

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REPORT SUMMARIZATION

A sample of 691 files was reviewed for this Company. Three hundred twenty-one (321) instances were seen that are considered by the Office to be in violation of Florida Statutes. The following represents general findings, however, specific details are found in each section of the report.

Sample Files Reviewed – 691 Files

- Private Passenger Automobile – 65 files
- Complaints – 50 files
- Cancellations – 50 files
- Claims – 526 files

Findings

- Private Passenger Automobile – Twenty-seven (27) violations – page 3 of the report
  - Failure to provide notice of renewal premium
  - Failure to follow the filed rates, rules or underwriting guidelines
- Complaints – Sixteen (16) violations – page 4 of the report
  - Failure of agents to return premiums timely
  - Failure to notify the insured of the amount of return premium that was returned to the premium finance company and the amount of unearned commission held by the agent
  - Failure to adjust the claim in compliance with contract or law
- Cancellations – Forty (40) violations – page 5 of the report
  - Failure of agents to return premiums timely
  - Failure to notify the insured of the amount of return premium that was returned to the premium finance company and the amount of unearned commission held by the agent
- Claims - First Sample Set – Twelve (12) violations – page 6 of the report
  - Failure to comply with PIP benefits requirements
  - Failure to adjust the claim in compliance with contract or law
  - Failure to timely disclose policy information
- Claims - Second Sample Set –Two hundred twenty-six (226) violations – page 8 of the report
  - Failure to comply with PIP benefit requirements, pay within 30 days of written notice
  - Failure to comply with PIP benefit requirements, providing an itemized specification of payments and denials
  - Failure to utilize an independent medical examiner of the same licensure as the treating physician
  - Failure to respond to a Division of Consumer Services inquiry within 20 days

PURPOSE AND SCOPE OF EXAMINATION

Under authorization of the Financial Services Commission, Office of Insurance Regulation, Market Investigations (Office), pursuant to Section 624.3161, Florida Statutes, a target market conduct examination of United Automobile Insurance Company (Company) was performed by Examination Resources, LLC from May 2, 2006 until June 16, 2006 and Insurance Consulting Company, LLC from April 26, 2007 until May 25, 2007. The scope of this examination was January 1, 2005 through March 31, 2007.

The purpose of this examination was to review the Company's underwriting practices related to new and renewal business of Private Passenger Automobile, review of cancellations/non-renewals, complaints and claims in an effort to determine compliance with the Florida Insurance Code. The Company records were examined at 3909 NE 163rd Street, North Miami Beach, Florida.

This Final Report is based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company. The files examined were selected systematically from data files provided by the Company using Microsoft Excel's "random sample" selection process. Procedures and conduct of the examination were in accordance with the Market Regulation Handbook produced by the National Association of Insurance Commissioners.

Error tolerance levels applied are as follows: monetary returns under $5.00 were waived; zero tolerance levels were applied to all improprieties by the Company which were in violation of Florida Statutes and Rules.

COMPANY OPERATIONS

United Automobile Insurance Company is a domestic property and casualty insurer licensed to conduct business in the State of Florida.

Total written premiums during the scope of the examination are broken down as follows:

Year	Total Written Premium (Florida)
2005	$280,176,709
2006	$358,521,912
2007*	$90,989,990

*Through March 31, 2007

PRIVATE PASSENGER AUTOMOBILE POLICY REVIEW

Findings

The Company had 204,083 private passenger automobile policies in force as of March 31, 2006. Sixty-five (65) policies were reviewed of which 40 were new business and 25 were renewals.

Twenty-seven (27) violations were found.

The violations are broken down as follows:

1. In twenty-five (25) of the policy files reviewed the Company failed to provide proper notice of renewal premium. Section 627.7277(2) and (3), Florida Statutes, requires the Company to provide notice of the renewal premium to the insured at least 30 days prior to the policy expiration. The Company does send a notice of renewal on time; however, the notice does not state the premium amount. The premium is left blank and at the bottom of the form, the insured is advised to contact the agent for a renewal quote. When the insured contacts the agent, a new application and a new Motor Vehicle Report (MVR) are produced. The MVRs on 24 of the 25 renewal files reviewed did not show any new information and thus no premium effect. However, in one instance the MVR did reveal a new violation that would have had a premium effect.

   Corrective Action: The Company should ensure that policyholders are properly notified of the renewal premium at least 30 days prior to the expiration of the policy.

2. In two (2) of the policy files reviewed the Company failed to follow the filed rates, rules or underwriting guidelines. Section 627.0651, Florida Statutes, states that an insurer shall use and follow rules or underwriting guidelines. In one case, the Company applied three points for an at fault accident. The accident had occurred 35 months prior to the inception date for which the Company's filed rating plan states that it will waive accidents. This error resulted in an overcharge totaling $302.60 for which the Company has issued an endorsement and refunded $302.60 to the insured. In the second case the Company used an incorrect territory. This error resulted in an overcharge totaling $82.17 for which the Company has issued an endorsement and refunded $82.17 to the insured.

   Corrective Action: The Company should follow the filed rates, rules or underwriting guidelines.

COMPLAINTS REVIEW

The Company received 934 consumer complaints from January 1, 2005 through March 31, 2006. The Company has maintained complete records of all complaints received as required by Section 626.9541, Florida Statutes.

The following chart shows by quarter the number of complaints received by the Company from January 1, 2005 through March 31, 2006:

Quarter	Number of Complaints	Percent Change
March 2005	198	-
June 2005	186	-6%
September 2005	183	-2%
December 2005	184	1%
March 2006	183	-1%

Findings

Fifty (50) complaints were reviewed.

Sixteen (16) violations were found.

Those violations are broken down as follows:

1. In four (4) of the complaints reviewed there was a failure of the agents to comply with return of unearned premium requirements. The agents held refunds for several months after receipt. Section 627.848(1)(e), Florida Statutes, states that whenever a financed insurance contract is canceled, the insurer shall, within 30 days of the cancellation date, return the unpaid balance due under the finance contract, up to the gross amount available upon the cancellation of the policy, to the premium finance company and any remaining unearned premium to the agent or the insured, or both, for the benefit of the insured or insureds. Interest of $42.02, $15.56, $18.03 and $5.45 was not paid on these late refunds; however, during the examination the Company issued checks for the additional payments to the affected policyholders.

   Corrective Action: The Company should ensure that its agents timely return unearned premium to policyholders. The Company should pay 8% interest to all affected policyholders as required by Section 627.7283(3), Florida Statutes

2. In nine (9) of the complaints reviewed the Company failed to notify the insured of the amount of return premium that was returned to the premium finance company and the amount of unearned commission held by the agent. Section 627.848(1)(e), Florida Statutes, states that the insurer shall, within 30 days of the cancellation date, notify the insured and the agent of the amount of unearned premium returned to the premium finance company and the amount of unearned commission held by the agent.

Corrective Action: The Company should ensure that policyholders are notified of the amount of unearned premium that has been sent to the premium finance company and of the amount of the unearned commission held by the agent.

3. In three (3) complaints reviewed the Company failed to adjust the claim in compliance with contract or law. Section 626.877, Florida Statutes, states that claims shall be adjusted in accordance with the terms and conditions of the contract and of the applicable laws of this state. In one instance, the Company calculated the total loss on a motorcycle claim based on the average between the retail and trade-in value in the Kelley Blue Book instead of on the retail value. This violation resulted in an underpayment of $316 for which the Company has issued payment to the claimant. In the second instance, the company deducted $2,750 in salvage value when the correct amount should have been $1,350. In addition, the storage charges were not paid by the Company. The Company has issued payment of $1,400 to the claimant for the salvage; however, storage fees were still outstanding upon conclusion of the exam. In the third instance, the claim was denied due to material misrepresentation; however, the policy was not rescinded.

   Corrective Action: The Company should adjust claims in compliance with the contract or law. The Company should rescind policies for which a claim is denied due to material misrepresentation and refund all premiums collected. If the policy has not been rescinded and the premium refunded, all claims should be handled on their respective merits.

CANCELLATION/NONRENEWAL REVIEW

Based upon a review of the sample files, the Company is in compliance with providing the advance cancellation/nonrenewal notices within the number of days as required by Section 627.7281, Florida Statutes. A copy of the notice is provided to the insured, agent, and lien holder, if applicable. Cancellation by the insured is calculated at 90% of pro rata and cancellation by the Company is calculated at pro rata. The Company's premium refund procedures are to send the unearned premium to the premium finance company net of agent commission. The premium finance company in turn sends any overpayment to the agent. The agent is required to send the unearned commission plus any money received from the premium finance company to the policyholder within 15 days.

Findings

Fifty (50) cancellations/nonrenewals were reviewed.

Forty (40) violations were found.

Those violations are broken down as follows:

1. There were twenty (20) violations in which there was a failure by the agent to comply with return of unearned premium requirements. The agents held refunds for several months or did not send refunds at all. Section 627.848(1)(e), Florida Statutes, states that whenever a financed insurance contract is canceled, the insurer shall, within 30 days of the cancellation date, return the unpaid balance due under the finance contract, up to the gross amount

available upon the cancellation of the policy, to the premium finance company and any remaining unearned premium to the agent or the insured, or both, for the benefit of the insured or insureds. This resulted in 14 under-returns totaling $1,063.11, which included interest. In the other 6 instances, which involved the refund being made late, the interest should be waived as it falls under the $5.00 error tolerance. The Company has issued refunds of $1,063.11.

Corrective Action: The Company should ensure that its agents send the unearned premium to the policyholders in a timely manner. In addition, the Company should audit each policy cancelled during the scope period having a refund of unearned premium to confirm that the gross amount of unearned premiums and commissions were refunded to the insured. Any premiums or commissions not already refunded to the insured should be paid either by the premium finance company, by the agent, or if necessary, by the Company. Interest should be paid on any un-refunded amounts owed more than 30 days after cancellation. A report should be provided to the Office detailing the results of the audit.

2. There were twenty (20) violations where the Company failed to notify the insured of the amount of unearned premium that was returned to the premium finance company and the amount of unearned commission held by the agent. Section 627.848(1)(e), Florida Statutes, states that the insurer shall, within 30 days of the cancellation date, notify the insured and the agent of the amount of unearned premium returned to the premium finance company and the amount of unearned commission held by the agent.

   Corrective Action: The Company should ensure that policyholders are notified of the amount of unearned premium that has been sent to the premium finance company and of the amount of the unearned commission held by the agent.

CLAIMS REVIEW – FIRST SAMPLE SET

Private Passenger Automobile insurance claims were reviewed, including claims for bodily injury, personal injury protection, property damage, comprehensive (fire, theft and glass), and collision.

Findings

In the first sample selected, 100 claims were reviewed. The sample was divided as follows:

Personal Injury Protection (PIP) - 50	Glass – 10
Property Damage (PD) – 15	Comprehensive – 5
Bodily Injury (BI) - 10	Collision – 10

Twelve (12) violations were found. Eleven (11) violations involved PIP claims and 1 violation involved a PD claim.

Those violations are broken down as follows:

1. In one (1) of the claim files reviewed the Company failed to comply with PIP benefit requirements. Section 627.736(4)(c), Florida Statutes, states that overdue payments shall bear simple interest at the rate established under Section 55.03, Florida Statutes. The medical bills were received in October 2004 and paid in March 2005. The Company did not obtain a waiver of interest from the provider.

   Corrective Action: The Company should process payment of PIP claims in a timely manner. In these instances when payments are made late, the Company should either pay interest on the late payment or obtain a waiver of interest from the provider.

2. In two (2) of the claim files reviewed, the Company failed to comply with PIP benefit requirements by failing to pay PIP benefits timely. Section 627.736(4) (b), Florida Statutes, states that benefits shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. Without justification, the Company failed to pay bills from two claimants. These errors resulted in two underpayments totaling $1,054.40. The Company has issued checks to the medical providers for the claims plus interest.

   Corrective Action: The Company should process payment of PIP claims in a timely manner.

3. In one (1) claim file reviewed, the Company failed to adjust the claim in compliance with contract or law. Section 626.877, Florida Statutes, states that every claim shall be adjusted in accordance with the terms and conditions of the contract and of the applicable laws of this state. The violation was due to a delay in paying the property damage claim.

   Corrective Action: The Company should adjust claims in accordance with the contract and law.

4. In four (4) of the claim files reviewed, the Company without reasonable justification failed to pay PIP benefits within 30 days. Section 627.736(4) (b), Florida Statutes, states that benefits shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. This violation was also cited in the previous examination of the Company, conducted in 2003.

   Corrective Action: The Company should process payment of PIP claims in a timely manner.

5. In one (1) claim file reviewed, the Company failed to adjust the claim in compliance with contract or law. Section 626.877, Florida Statutes, states that claims shall be adjusted in accordance with the terms and conditions of the contract and of the applicable laws of this state. The Company miscalculated the amount of PIP payments owed. This violation resulted in an underpayment totaling $128. The Company has issued payment to the medical provider for the full amount of the claim plus interest.

   Corrective Action: The Company should adjust claims in accordance with the contract.

6. In three (3) of the claim files reviewed, the Company failed to timely disclose policy information when requested. Section 627.4137(1), Florida Statutes, states that the insurer shall supply the information required by the Statute within 30 days of receipt of such request.

   Corrective Action: The Company should provide timely disclosure of information required by statute.

CLAIMS REVIEW – SECOND SAMPLE SET

It was determined that further review of the Company's handling of Personal Injury Protection (PIP) and Property Damage (PD) liability claims was warranted. A second sample of 426 Private Passenger Automobile insurance claims was reviewed. The significant increase in the number of files reviewed and the inclusion of PIP claims open longer than 6 months resulted in an increase in the number of violations discovered. The sample was divided as follows:

100 PIP claims closed with payment	100 PIP claims closed without payment
100 PIP claims open more than.6 months	50 PIP claims with complaints
76 PD claims	

In the sample of 426 Private Passenger Automobile claim files reviewed, there were a total of 234 instances considered by the Office to be violations of Florida Statutes.

Findings

PIP Closed With Payment

One hundred (100) randomly selected closed with payment PIP claims files were reviewed. A total of seventy-nine (79) violations were found.

Those violations are broken down as follows:

1. In forty-five (45) of the one hundred (100) claim files reviewed, the Company failed to comply with PIP benefit requirements by failing to pay PIP benefits within 30 days. Section 627.736(4) (b), Florida Statutes, states that benefits shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. In seven (7) instances the delays in paying bills were without reasonable justification. In thirty-eight (38) instances, the claims were under investigation but were later found to be compliant, within coverage, or were otherwise settled for business reasons. This violation was cited in the previous examination of the Company conducted in 2003.

   The evaluations of payments and interest were complicated by the utilization of global settlements. These settlements are made with providers and involve billings from multiple claims on litigated matters. The claim files contain no summary or itemization of payment other than a notation in the adjuster's notes. In addition, claim files wherein some or all of

the providers have pursued payment through litigation have incomplete documentation as the discussion and documentation in the litigation files is not consolidated into the claim files.

Corrective Action: The Company should process payment of PIP claims in a timely manner. For accuracy of internal claim handling the company should enforce existing procedures relating to the maintenance and updating of benefit payment logs.

2. In twenty-nine (29) of the claim files reviewed, the Company failed to provide proper Explanation of Benefit forms (EOBs). Section 627.736(4)(b), Florida Statutes, states the insurer shall at the time of a partial payment or rejection provide an itemized specification of each item reduced, omitted, or declined. The claims files either lacked one or more EOBs, or the EOB that was produced was incomplete or inaccurate.

   Corrective Action: The Company should provide timely and accurate explanations of benefits to insureds and providers with a clear explanation of payments being rejected, reduced or paid. For accuracy of internal claim handling the company should enforce existing procedures relating to the maintenance and updating of benefit payment logs.

3. In one (1) claim file reviewed, the Company failed to utilize an independent medical examiner of the same licensure as the treating physician but relied on the opinion of that provider to suspend, limit or cease benefits for medical treatment. Section 627.736(7) (a), Florida Statutes, requires the company to have the examination performed by a Florida physician licensed under the same chapter as the treating physician.

   Corrective Action: The Company should ensure that independent medical examinations are performed by a Florida physician licensed under the same chapter as the treating physician, prior to suspending benefits.

4. In three (3) of the files reviewed, the Company did not send timely notices of the benefit suspension based on an Independent Medical Exam (IME), thereby placing the claimant on notice that there would be no coverage for future treatment.

   Corrective Action: The Company should provide timely notice of any suspensions of PIP benefits. The company has instituted corrective action through the use of their computer platforms which will automatically diary the IME process and flag such matters for supervisory review.

PIP Closed Without Payment

One hundred (100) randomly selected closed without payment Personal Injury Protection claims files were reviewed.

1. In one (1) of the files reviewed, the Company did not send a timely notice of the benefit suspension based on an Independent Medical Exam (IME), thereby placing the claimant on notice that there would be no coverage for future treatment.

Corrective Action: The Company should provide timely notice of any suspensions of PIP benefits. The company has instituted corrective action through the use of their computer platforms which will automatically diary the IME process and flag such matters for supervisory review.

PIP Open Claims

One hundred (100) randomly selected open Personal Injury Protection claims files were reviewed. Ninety-five (95) violations were found.

Those violations are broken down as follows:

1. In forty-eight (48) of the one hundred (100) claims files reviewed, the Company failed to pay PIP benefits within 30 days. Section 627.736(4) (b), Florida Statutes, states that benefits shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. In six (6) instances, the delays in paying bills were without reasonable justification. In forty-two (42) instances, the claims were under investigation by the Company but were later found to be compliant, within coverage, or were otherwise settled for business reasons. This violation was cited in the previous examination of the Company conducted in 2003.

   The evaluations of payments and interest are complicated by the utilization of global settlements. These settlements are made with providers and involve billings from different claims on litigated matters. The claim files contain no summary or itemization of payment other than a notation in the adjuster's notes. In addition, claim files wherein some or all of the providers have pursued payment through litigation have incomplete documentation as the discussion and documentation in the litigation files is not consolidated into the claim file.

   Corrective Action: The Company should process payment of PIP claims in a timely manner. For accuracy of internal claim handling the Company should enforce existing procedures relating to the maintenance and updating of benefit payment logs.

2. In forty-one (41) of the files reviewed, the Company failed to comply with PIP benefit requirements as the result of a failure to provide proper EOBs. Section 627.736(4)(b), Florida Statutes, states the insurer shall provide at the time of a partial payment or rejection an itemized specification of each item reduced, omitted, or declined. The claims files either lacked one or more EOBs, or the EOB that was produced was incomplete or inaccurate.

   Corrective Action: The Company should provide timely and accurate explanations of benefits providing insureds and providers with clear explanation of payments being rejected, reduced or paid. For accuracy of internal claims handling the company should enforce existing procedures relating to the maintenance and updating of benefit payment logs.

3. In three (3) of the files reviewed, the Company did not send timely notices of the benefit suspension based on an Independent Medical Exam (IME), thereby placing the claimant on notice that there would be no coverage for future treatment.

   Corrective Action: The Company should provide timely notice of any suspensions of PIP benefits. The company has instituted corrective action through the use of their computer platforms which will automatically diary the IME process and flag such matters for supervisory review.

Consumer Complaints - Claims

Fifty (50) randomly selected claims files on which Division of Consumer Services complaint inquiries had been received were selected for review. Two (2) claim files could not be located. Forty-eight files were reviewed. Forty-one (41) violations were found in twenty (20) of the files reviewed:

1. In seventeen (17) of the fifty (50) complaint files reviewed, the Company failed to pay PIP benefits within 30 days. Section 627.736(4) (b), Florida Statutes, states that benefits shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. In five (5) instances, the delays in paying bills were without reasonable justification. In twelve (12) instances, the claims were under investigation but were later found to be compliant, within coverage, or were otherwise settled for business reasons.

   Corrective Action: The Company should process payment of PIP claims in a timely manner.

2. In seventeen (17) of the claim files reviewed, the Company failed to provide proper EOBs. Section 627.736(4)(b), Florida Statutes, states the insurer shall provide at the time of a partial payment or rejection an itemized specification of each item reduced, omitted, or declined. The claims files lacked one or more EOBs, or the EOB produced was incomplete or inaccurate.

   Corrective Action: The Company should provide timely and accurate explanations of benefits providing insureds and providers with an explanation of payments being rejected, reduced or paid. For accuracy of internal claim handling the company should enforce existing procedures relating to the maintenance and updating of benefit payment logs.

3. In two (2) files reviewed the Company failed to respond to the Division of Consumer Services within 20 days of their inquiry as required by Section 20.121(2)(h)2, Florida Statutes.

   Corrective Action: The Company should respond to all consumer complaint inquiries from the Division of Consumer Services within 20 days.

4. In two (2) instances, the Company was unable to provide a copy of the physical file. Section 628.271(1) (e), Florida Statutes requires the company to keep complete records of claim files.

   Corrective Action: The Company should ensure that complete claim files are maintained and available.

5. In three (3) of the files reviewed, the Company did not send a timely notices of the benefit suspension based on an Independent Medical Exam (IME) thereby placing the claimant on notice that there would be no coverage for future treatment.

   Corrective Action: The Company should provide timely notice of any suspensions of PIP benefits. The company has instituted corrective action through the use of their computer platforms which will automatically diary the IME process and flag such matters for supervisory review.

Property Damage Claims

Seventy-five (75) property damage claims were randomly selected for review. The physical file for one (1) claim could not be located and two (2) additional claim files were selected. A total of seventy-six (76) property damage claims were reviewed. Ten (10) violations were found.

Those violations are broken down as follows:

1. In nine (9) of the files reviewed, the Company failed to adjust the claim in compliance with contract or law. Section 626.877, Florida Statutes, states that every claim shall be adjusted in accordance with the terms and conditions of the contract and of the applicable laws of this state. The violations were due to delays in properly investigating and paying property damage claims.

   Corrective Action: The Company should adjust claims in accordance with the contract and law.

2. In one (1) instance, the Company was unable to provide a copy of the file for review. Section 628.271(1) (e), Florida Statutes requires the Company to keep complete records of claim files.

   Corrective Action: The Company should maintain records to ensure that complete claim files are available for review.

Litigation Review

As of March 31, 2006, the Company had 5,761 claims in litigation.

Ten (10) litigated claim files were reviewed to consider the appropriateness of the handling of the claim leading to litigation.

Findings

The Company made extensive use of Examinations Under Oath (EUO) and Independent Medical Exams (IME) to attempt to control PIP losses. Most IMEs resulted in discontinuance of coverage for future medical treatment. A letter to the insured or attorney advising of the discontinuance is routinely sent. Bills received that are not 100% compliant, are for treatment received after the discontinuance date, or are in excess of usual and customary rates, are denied. The handling of these ten (10) claims prior to and during litigation appeared to be appropriate.

Fraud Procedures Review

A review of the Special Investigations Unit (SIU) operation revealed a very active operation with multiple investigators. Cases are referred to the SIU by the adjusters when fraud is suspected. In the case of auto theft or auto fires, all cases are referred for the purpose of taking the insured's EUO. Claims are written into a log and copies of the referral sheets are placed into a binder, separated by month. Referrals are not entered into any electronic spreadsheet or system, making any quantitative analysis cumbersome. A review of a sample of claims indicates that almost every case where the claimant is treated by a chiropractor is referred by the adjuster to the SIU. The SIU then, in almost every case, refers the case to the Division of Insurance Fraud (DIF) and classifies it as "Under Investigation". In some cases, there are no indicators of fraud at the time of the referral. If the SIU develops further information indicating a strong likelihood of fraud, the complete file is hand-delivered to the Miami office of DIF.

During a prior market conduct examination, the Company was cited for not referring to DIF all cases in which fraud was suspected. However, the Company is now making a referral to DIF on almost every case involving chiropractic treatment. Additionally, cases involving auto theft or auto fire are referred to DIF, even when there are no indicators of fraud.

The following chart, provided by the Company, shows the number of referrals made by the Company to DIF from January 1, 2005 through February 28, 2006:

Month	Number of Referrals	Percent Change
January 2005	42	-
February/March 2005	80	48%
April/May 2005	100	20%
June/July 2005	175	43%
August/September 2005	177	1%
October/November 2005	311	43%
January/February 2006	146	-53%

Findings

Ten (10) DIF referrals were reviewed.

1. There were three (3) instances where a referral was not appropriate as there was no clear suspicion of fraud. The Company has advised that due to the results of the previous market conduct examination it refers to DIF everything that is referred to SIU by the adjuster.

   Corrective Action: The Company should comply with Section 626.989(6) by reporting to DIF only those claims believed to include fraudulent insurance acts or any other acts or practices which, upon conviction, constitute a felony or a misdemeanor under the code.

EXAMINATION FINAL REPORT SUBMISSION

The Office hereby issues this report as the Final Report, which is based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company.